

**State of Maine**

**Department of Human Services**

**Bureau of Elder and Adult Services**

**Request for Proposals #G101222**

**Home Care Coordination Agency (HCCA) for:**

Home Based Care for Elders and Other Adults

Medicaid Home and Community Based Waiver for Elders and  
Adults with Disabilities

Medicaid Private Duty Nursing and Personal Care Services



January 2001

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## **SECTION I**

### **INTRODUCTION**

The purpose of this Request for Proposals (RFP) is to select an agency(ies) to function as the home care coordination agency (HCCA) effective July 1, 2001, through June 30, 2002. Future contracts will be renewable, at the option of the Department, for four one-year periods from July through June.

The Maine Department of Human Services, hereinafter referred to as the Department, administers a range of long-term care programs. Services provided through the following Departmental programs are arranged and coordinated by the HCCA:

- A. **Home Based Care (HBC): In-Home and Community Support Services for Elderly and Other Adults.** This state-funded program provides in-home services to help older and disabled persons stay at home and to prevent unnecessary admissions to an institution. The goals of HBC include:
1. Helping persons who might otherwise be institutionalized to stay at home;
  2. Promoting independence and self-care; and
  3. Working with and enhancing family and community resources.

In SFY 00 an *average* of 1,591 consumers were served *each month* statewide. Individual monthly care plan costs are funded based on four levels of eligibility, with the highest care cost not allowed to exceed 85% of the average monthly expenditure per consumer for nursing facility level of care. (See BEAS Policy Manual Section 63 for a description of the four levels.)

The amounts per level are currently set at: Level 1 = \$1,000.00; Level 2 = \$1,250.00; Level 3 = \$1,800.00; Level 4 = \$3,266.93.

- B. **Maine's Home and Community Based Waiver for Elders and Adults with Disabilities (MW).** This Medicaid-funded program serves persons aged 18 and older who would qualify for the level of care provided in a nursing facility. In SFY 00 an *average* of 1,083 consumers were served *each month* statewide. An individual's annual care plan cost cannot exceed 100% of the average annual Medicaid expenditure per consumer for nursing facility level of care.
- C. **Private Duty Nursing and Personal Care Services.** This Medicaid program provides private duty nursing and personal care services to adults who meet the community financial eligibility standard and certain functional criteria. Two levels of care are available including "At Risk PDN" and "Extended Level PDN." In SFY 00 an *average* of 765 consumers were served *each month* statewide. Nursing services and personal care services are provided to consumers in their homes based on an authorized care plan specifying the level and units of service. Individual care plans for "At Risk PDN" may not exceed \$1,060 per month, and \$20,100 per month for "Extended Level "PDN".

The following table provides information regarding actual consumers served and service expenditures for the past three years. The numbers in the table reflect an *unduplicated annual* count of consumers served.

<b>TABLE 1: HCCA PROGRAMS – EXPENDITURES AND NUMBER OF CONSUMERS SERVED</b>						
<b>PROGRAMS</b>	<b>SFY 98</b>		<b>SFY 99</b>		<b>SFY 00</b>	
	<b>Total</b>		<b>Total</b>		<b>Total</b>	
	<b>Expenditure</b>	<b>Cnsmrs</b>	<b>Expenditure</b>	<b>Cnsmrs</b>	<b>Expenditure</b>	<b>Cnsmrs</b>
Private Duty Nursing (adults only)	\$575,833	82	\$892,712	355	\$1,149,190	869
Waiver: Elder & Adults	\$14,604,975	1,618	\$21,521,767	1,904	\$21,190,181	1,776
Home Based Care: Elder & Adults	\$7,083,230	1,772	\$8,266,300	2,547	\$12,004,121	3,056

The medical and functional eligibility determination for these programs is done through a single pre-admission assessment called the Medical Eligibility Determination (MED), using the computer application known as MeCare. The intake, pre-screening, assignment, assessment, and resulting authorized plans of care for each consumer are administered statewide by a single assessing services agency (ASA), which is currently Goold Health Systems, Inc. To ensure objectivity and prevent conflict of interest, the HCCA may not provide pre-admission assessment or provide, either directly or through an affiliate, any long-term care services. The Department reserves the right to determine to what extent a respondent is affiliated with a provider of long-term care services. Long-term care services include, but are not limited to, personal care, home health, homemaker, skilled nursing, adult day services, licensed assisted living, fee-for-service care management, durable medical equipment, or nursing facility care.

The HCCA coordinates and arranges services for consumers assessed and found eligible by the assessing services agency. The HCCA is responsible for implementing and case managing service plan activities as prior authorized on the MED form for eligible consumers for the Home Based Care, Elderly and Adults with Disabilities Waivers, Private Duty Nursing & Personal Care Services. All program provisions are subject to federal and state law and regulation, including but not limited to the BEAS Policy Manual and the Maine Medical Assistance Manual and any amendments thereto. Respondents are advised to refer to these policies, available respectively from BEAS and the Bureau of Medical Services. The applicable sections of the Maine Medical Assistance Manual are Section 18 – Home and Community Based Waiver Services for Adults with Disabilities; Section 19 – Home and Community Based Waiver Services for the Elderly; and Section 96 – Private Duty Nursing and Personal Care Services.

In addition to the substantial number of consumers served (see Table 1), at any one time, there are 225-250 provider agencies with whom contracts must be established. Providers bill the HCCA bi-weekly; these bills are normally processed within 24-48 hours of receipt. The HCCA reviews and reimburses providers for Home Based Care funded services. In addition, the HCCA is the provider of record for PDN and Medicaid Waiver services. The HCCA submits all PDN and Waiver bills to the Bureau of Medical Services (BMS) twice weekly for Medicaid reimbursement. This involves preprocessing bills for compliance using Medicaid claims standards to identify needed corrections and returning problematic invoices to providers for correction, including bills that should have been

submitted to third party payers (e.g. Medicare). Once bills are approved by BMS, the HCCA reimburses the provider.

The goals of home care coordination services are to:

- A. Support consumers and families in using home care services to maintain maximum feasible independence
- B. Promote high quality services
- C. Emphasize rehabilitation, health promotion, and efficient use of financial and human resources

These goals will be achieved by:

- A. Qualified care management staff to review, coordinate and monitor the delivery of services to consumers, and identify unmet needs and provide linkage to community resources through face to face visits and regularly scheduled and unscheduled telephone contact.
- B. Delivering quality customer service and advocating on behalf of HCCA consumers
- C. Assuring that the least restrictive and/or most cost effective services are implemented as authorized on the plan of care
- D. Managing a single statewide waiting list for services for each program administered by the HCCA
- E. Collecting and analyzing data for better program management and policy development
- F. Maintaining an electronic information system for accepting assessments and authorized service plans, processing claims and statewide data, and conducting specified utilization review activities
- G. Implementing quality monitoring and improvement systems
- H. Educating consumers, families, and interested parties about the functions of the HCCA

Respondents other than the current HCCA must indicate how long a transition period will be needed and project the costs involved for that period, for which the Bureau will provide funds separate from the HCCA reimbursement rate. The Bureau may cover some or all of the proposed transition costs to the extent that they are reasonable and subject to the availability of funds. Transition funds will not be provided, however, if a proposal from the current provider is selected.

The Bureau will make available \$50,000 for required DHS training of HCCA staff due to changes in policies and procedures across multiple programs administered by the HCCA.

## **SECTION II**

### **SCOPE OF WORK FOR**

### **HOME CARE COORDINATION AGENCY**

#### ***HOME CARE COORDINATION ACTIVITIES***

To successfully achieve the goals of this service, the HCCA must have staff with knowledge of available services and experience using problem solving skills to implement authorized care plans that match the needs of the consumers. HCCA staff will be trained by the HCCA, the Department, and other entities, as appropriate, regarding community options, policy and procedure, and use of the MeCare system. The HCCA and ASA will participate in each other's training when appropriate, and any mandated training provided by the Department. The HCCA will conduct the following activities on behalf of consumers for whom they are coordinating, monitoring and arranging services:

- A. Compile and maintain detailed and updated information on community options, statewide and local programs, and providers of long term care services. The resource file will include policy manuals and descriptions of all programs and services including but not limited to:
  - 1) Medicaid and State-Funded Consumer Directed Attendant Services
  - 2) Targeted Case Management
  - 3) Medicaid Home and Community Based Services (HCBS) Waivers
  - 4) Adult Day Health
  - 5) Adult Day Services
  - 6) Private Duty Nursing/Personal Care Services
  - 7) Medicaid Home Health
  - 8) Home Based Care services for Elders
  - 9) Consumer Directed Home Based Care
  - 10) Homemaker services
  - 11) Home delivered meals
  - 12) Congregate Housing Services
  - 13) Medicare Home Health
  - 14) Low Cost Drugs for the Elderly and Disabled
  - 15) State Health Insurance Counseling Program
  - 16) Alzheimer's Respite Services
  - 17) Regional and local volunteer resources

For each of these programs, the HCCA must have information regarding:

- a. Eligibility for services;
- b. Sources of payment;
- c. Copayment requirements;
- d. Lists of service providers;
- e. Waiting lists;
- f. Characteristics of specific service providers (e.g. which home health agencies provide "Personal care assistants" and level of licensure);

- g. Usual and expected duration of services;
- h. Cost caps or limitations per program;
- i. Desired outcomes of services;
- j. Allowable maximum costs per unit of service per funding source;
- k. Covered and non-covered services under each funding source.

This information will be updated regularly and be available to staff to assist in care plan implementation.

- B. Maintain normal business hours of 7:00 a.m. until 7:00 p.m., Monday through Friday, to assure availability of HCCA staff to consumers, providers and the public in order to address consumer problems and be responsive to changing consumer needs.
- C. Maintain on-call twenty four (24) hour service availability for weekends and all holidays. Inform consumers, the Department and providers of the protocol for contacting the HCCA for after hour assistance.
- D. Maintain offices in at least two locations to serve the southern and northern areas of the state, both with full access to data.
- E. Employ either directly or through contract staff who are either a licensed social worker or registered professional nurse with at least one year of community services experience. Staff must have demonstrated leadership ability, strong clinical, problem solving, organizational, and interpersonal skills and possess an extensive knowledge of community resources and reimbursement systems for health and social services.
- F. Train staff as necessary to ensure compliance with the contract requirements and policy administration including but not limited to:
  - 1) Working effectively with consumers and service providers in variable situations;
  - 2) Admission and discharge processes including due process and official notification time requirements for termination of services, appeals, and administrative hearing rights;
  - 3) Record keeping requirements for various funding sources to comply with policy and audit criteria;
  - 4) How to arrange for all other formal and informal services in the ASA authorized care plan that are not funded by the HBC, Waiver or Private Duty Nursing/Personal Care Services programs, and any other activities necessary to carry out the plan of care.

If a new HCCA provider is selected as a result of this RFP, the Department will provide training within 30 days of the effective date of the contract on the Long Term Care Systems, Community Options, and the assessment process.

- G. Provide objectives and outlines for all training programs on the HCCA internal procedures to assure compliance with contract requirements and relevant policy manuals. The HCCA will develop and document a formal program of orientation for professional and other support services staff that outlines the topics, presenters and timeframes for completion of orientation. All training resource materials and attendance reports are submitted to the Department for review and signoff.

- H. Have staff review the MED with special emphasis to the careplan tab and assessor notes on the MeCare feed to gain an understanding of the individual consumer's circumstances and assess how to best work with the consumer and/or family to implement the authorized plan of care and allow consumers choice in the provider contracted to deliver the authorized services.
- I. Place the consumer's name on a waiting list and notify the consumer of the approximate waiting period if funds or service provider personnel are unavailable. The HCCA shall arrange for any care plan services that can be paid for by other funding sources and refer to other interim funding sources such as Alzheimer's Respite.
- J. Contact the consumer to discuss choice regarding providers and options within seventy-two (72) hours of receipt of the MED outcome via MECARE.
- K. Implement the careplan no later than five (5) working days after receipt of the MED/MeCare when funds and staffing are available. The HCCA may bill for its care coordination services (HCCA fee) beginning on the day an assessed consumer has been contacted to discuss implementing the plan of care. A HCCA fee cannot be submitted for any month during which a consumer did not receive in-home care services, except when services were not received because of provider staffing shortages, or for any month during which no care coordination or monitoring activity has occurred.
- L. Contact consumers each month to verify receipt of authorized services, discuss consumer's status and satisfaction with care provided, review any unmet needs to allow for appropriate follow-up and referral to community resources.
- M. Conduct quarterly face-to-face visits with all Medicaid Waiver, nursing facility level Home Based Care, and other home care consumers, as authorized by the ASA, or as necessary.
- N. Document all interventions with or on behalf of consumers on a timely basis.
- O. Determine the actual HBC consumer copayment by:
  - 1) Informing all consumers to be assessed a copayment or cost of care payment the estimated monthly copayment amount
  - 2) Collecting the additional information required to calculate the actual HBC copayment
  - 3) Explaining the actual copayment to be made
  - 4) Obtaining the consumer's signature agreeing to the co-payment for HBC once all required information is collected and the actual copayment determined
  - 5) Communicating new and/or revised information to the ASA on the referral request for reassessment if the HCCA, as part of the copayment or waiver of copayment process determines that the amount of income and/or assets differs from the information provided to the assessor at the time of assessment
  - 6) Alerting the ASA when requesting a non-routine HBC reassessment so that the financial information is not collected, and have the assessor explain to the consumer that the HBC copayment is calculated only once a year when the required annual financial reassessment is done
- P. Process all waivers of copayment requests for HBC consumers, following all applicable policy.

- Q. Inform the consumer of policy requirements regarding non-payment and termination of services across all programs administered by the HCCA.
- R. Make a referral to the appropriate agency for outreach assistance to help consumers applying for Medicaid programs who need help in completing the Bureau of Family Independence (BFI) application and providing the required documentation.
- S. Document the level and choice of provider that best matches the needs for each consumer within the allowable policy parameters and based on the authorized plan of care.
- T. Arrange services to be provided to consumers based on discussions with the consumer, and availability of services from provider(s) chosen by the consumer staying within the monthly authorized plan of care, program maximum allowance and the policy parameters.
- U. Arrange for all other formal and informal services in the authorized care plan that are not funded by the HBC, At Risk and Extended level PDN/PCS or Waiver programs, and any other activities, formal or informal necessary to carry out the plan of care.
- V. Provide a copy of the HCCA's authorized service plan, as defined in the BEAS Policy Manual, and the MED/ MeCare assessment to the following:
  - 1) Consumer
  - 2) Responsible party, when applicable
  - 3) Providers involved with the care, upon request
- W. Contact the consumer within five (5) days of the start date on the service authorization to verify that services have been initiated. This may serve as the monthly contact for the month in which the consumer is admitted to the program. For new waiver recipients, the initial quarterly care monitoring visit will occur within thirty (30) days of admission to the program.
- X. Respond in a timely manner to questions, problems, or complaints from consumers, family members, friends, providers, nurse assessors, or advocates concerning community long term care services by identifying, investigating, substantiating and working to resolve the issue that prompted the contact. BEAS requires additionally that the HCCA establish a complaint procedure which includes a written log documenting the date, source and time of complaint, investigation and resolution. On a quarterly basis, the HCCA will report to the Department all complaints that impact on the plan of care, especially staff performance (HCCA and/or subcontracted providers), notification of non service delivery, and non-availability of service hours.
- Y. Request reassessment from the ASA if information gathered during the current eligibility period authorized by the ASA indicates that a significant change occurred in the consumer's level of function that presumes a different level of care or program may be applicable. Request reassessment from the ASA if information gathered during the current eligibility period authorized by the ASA indicates that the consumer requires additional services based on a change in need such as a change in function, less than meets the definition of significant change, medical condition, or change in informal supports. Consumers who move from one independent housing situation to a more supportive environment, such as an assisted living facility, must be reassessed to determine continued program eligibility and appropriateness of the plan of care.

Z. Authorize in the event a consumer experiences:

- 1) An unexpected need; the HCCA has the authority to adjust the frequency of services under the authorized care plan, in order to meet the needs, as long as the total authorized care plan hours for the eligibility period are not exceeded
- 2) An emergency or acute episode as defined in BEAS policy; the HCCA has the authority to adjust the authorized plan of care up to 15% of the monthly authorized amount not to exceed the applicable cap. Services resulting from an acute or emergency incident may not continue beyond fourteen (14) days and the HCCA must request a reassessment on the date the increase is implemented.

AA. Make referrals to the Ombudsman, Adult Protective Services, or Licensing and Certification organizations when appropriate or as required by law.

### ***HOME CARE COORDINATION MANAGEMENT***

In order to be reimbursed for home care coordination at the negotiated rate,<sup>1</sup> (HCCA fee) the HCCA will also:

A. Establish sufficient subcontracts to provide statewide availability of home care services and:

- 1) Provide assurance that all subcontractors perform criminal background checks on all in-home and community support service providers and certify that all PCAs meet training requirements.
- 2) Provide subcontractors with copies of policy and maximum rate allowances for each funding source.
- 3) Amend subcontractors' contracts when Department authorized rate changes are implemented and assure retroactive reimbursement to providers back to the effective date of the rule change. BEAS will consider an increase in funding to compensate the HCCA for temporary personnel costs, based on justification provided by the HCCA and on the availability of funds.
- 4) Include a requirement in subcontracts, amendments or renewals, that providers will comply with specific provisions of rate increases appropriated by the Legislature for direct care staff.

B. Perform the following activities:

- 1) Transmit service orders and other relevant documents to the service provider on paper or, whenever possible, via electronic transmission;
- 2) Require subcontractors to notify HCCA within five (5) days of inability to deliver services to a consumer;
- 3) Substitute lower cost services of comparable quality when available.

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<sup>1</sup> Home care coordination is defined by Medicaid as "case management administration".

- 4) Audit 20% of subcontracts to assure compliance with all policy parameters, verify certification, license, and training requirements according to specific policy.

C. Provide administrative support to:

- 1) Accept and track receipt of the MeCare feed and utilize information provided in MeCare to administer the various programs and coordinate, implement and monitor the plan of care.
- 2) Track reassessment due dates and make timely referrals to the ASA that include the actual careplan in MeCare terms and units, any pertinent information concerning the consumer that may have occurred since the electronic referral request or last assessment, or any MDT findings that may impact on the assessment and the authorized plan of care; indicate on the referral request if family members are currently providing the paid care as a personal care assistant or whether the consumer is a voucher recipient.
- 3) Assign referrals to appropriate staff. For waiver recipients the face to face care monitoring visit must occur within thirty (30) days of the initial plan of care implementation.
- 4) Complete and submit required documents to the Department.
- 5) Send the necessary documents to the home health agency or other appropriate agency chosen by the consumer to provide services authorized in the careplan no later than 5 days from the date the referral is received by the subcontractor.

D. Support consumers and families by:

- 1) Maintaining an average caseload size of 70 consumers per licensed, full-time equivalent staff
- 2) Reviewing MED/MeCare careplan implementation for compliance with the authorized careplan amount
- 3) Evaluating accuracy of the service orders to assure that tasks reflected on the authorized plan of care have been specified
- 4) Evaluating the problem solving skills of staff, including, but not limited to, identifying variations in frequency of follow up contacts from consumers and providers because of errors in the implementation of the authorized plan of care, the calculation of careplan services and measuring against the performance requirements contained herein and taking corrective action as necessary
- 5) Establishing an internal quality assurance process that documents the following activities: record reviews, case conferences, convening of MDTs, compliance with due process procedures, and soliciting feedback from consumers and families
- 6) Returning 100% of consumer and provider calls by 4:30 p.m. the same day, if the inquiry comes in by noon, or by 10:00 a.m. the following work day, if the inquiry comes in after noon.
- 7) Document employee counseling and the development of a work plan that addresses the identified issues, method and goals for improvement and timeframe for resolution.

- E. Ensure that the requirements of the following are met:
- 1) BEAS Policy Manual;
  - 2) HCCA contract;
  - 3) Memorandum of Agreement between the Bureau of Elder and Adult Services and the Bureau of Medical Services (as it relates to the role of subcontractors);
  - 4) Maine Medical Assistance Manual and waiver documents.
- F. Meet periodically at Quality Assurance Review Committee (QARC) or other forums, and with the Department, hospitals, assessing service agency, home health agencies, Ombudsman, area agencies on aging, and other interested parties to identify issues related to the HCCA's contract to:
- 1) Conduct problem solving
  - 2) Ensure compliance with procedural operational agreements that have been documented in meetings between the Department and the HCCA
  - 3) Report to BEAS any problems in the system or with individual providers that may indicate a need for policy or legislative change, for more training, or for other outreach activities
  - 4) Report to the ASA any problems that involve assessment services
- G. Maintain a minimum of 90% consumer satisfaction as measured by a survey conducted by the Department or its designee. One percent of the monthly HCCA fee per consumer will be withheld, to be paid based on the outcome of the annual consumer satisfaction survey.
- H. Maintain a management information system that is capable of:
- 1) Accepting MED/McCare data, from the assessing agency for eligible HBC, PDN, ADW and MW consumers and Medicaid Home Health when applicable.
  - 2) Retaining care plans, progress notes, records of services provided, other communications from consumers, family members, physicians, and service providers.
  - 3) Logging service orders and matching them against the McCare authorized plan of care, and actual services delivered based on invoices.
  - 4) Managing the payment process, including the following items and tasks:
    - a. Service authorizations;
    - b. Bills from service providers;
    - c. Matching of bills with service authorizations;
    - d. Submitting Medicaid reimbursable bills to BMS;
    - e. Collecting of copayments;
    - f. Reimbursing providers;
    - g. Tracking the difference between services delivered and billed from the amount of services authorized and conducting follow up with the provider agencies about

discrepancies. Providing monthly report to BEAS on status of non delivery of authorized services by total units undelivered and program funding source, providing categories of reasons why services could not be provided.

- 5) Submit the following reports electronically to BEAS by funding source. These reports will include definitions of terms and categories used by the HCCA, allowing BEAS to compare and analyze data with MeCare:
  - a. Service order totals by program for direct services authorized and the home care coordinating activities no later than the 5th of the month.
  - b. Documentation of specific utilization review activities to determine that services provided by program/funding source do not exceed or substantially differ from service authorizations, and that funds are not overspent, by cross checking for:
    - i. Cost caps authorized by the ASA with service plan orders
    - ii. Cost caps authorized by the assessing services agency with actual payments
    - iii. Service authorizations with claims submitted
    - iv. Follow up with providers on services which were authorized but NOT delivered. Maintain a record each month of hours/visits of service not delivered by individual service providers.
  - c. Consumers by name and funding source, that have received the care coordination service only and no other direct care services;
  - d. Waiting list number of consumers by funding source;
  - e. Active new admissions, readmit, new discharge and redischarge lists that include client name, identification number, admit date, service start date and discharge date and reason that matches MeCare definitions when applicable and the unduplicated consumers year to date;
  - f. Monthly expenditures by county and statewide including number of units of service and cost per service category, total number of consumers served, total expenditures adjusted for copayment revenues.

The HCCA will assure that any necessary programming will be completed in order to comply with the reporting requirements of this contract and by reprocessing on a quarterly basis these reports to adjust for out of timeframe admissions and discharges.

The HCCA must provide a hard copy and a disk with the data to the Department. Bills received after the required deadline risk non-payment by certain Department funding sources.

- 6) Integrating the HCCA's information system into MeCare and providing the Department on line, real time access to the consumer record

<b>TABLE 2: DATA MAINTAINED FOR HBC AND MW BY HOME CARE COORDINATION AGENCY</b>			
	<b>Data Received From</b>	<b>Data Used For</b>	<b>Reported to:</b>
<b>MeCare</b>	Assessing Services Agency	Implementing care plans Issuing service orders Utilization review	BEAS  BMS
<b>Service Orders</b>	Internal	Cross check with MeCare findings	Internal and BEAS
<b>Authorized Care Plans</b>	Care plan tab/screen on MeCare	Compare authorized careplan with authorized service plan of care Feedback actual plans of care to MeCare	Internal and BEAS
<b>Services Billed and/or Paid for</b>	Subcontracted providers	Cross check with authorized service orders and follow-up on non-delivered authorized service orders.	BEAS BMS

- I. Electronically transmit data from MeCare and electronically distribute MED/ MeCare data as specified by the Department, using computer software provided by the Department.
- J. Process the data feeds received from MeCare and provide data in a feed to MeCare (actual care plan data), in a suitable location accessible to the state via ftp for processing the feed files.
  - 1) MeCare is certified to run on standalone PCs with TCP/IP access to MeCare server. Any installation other than a standard desktop installation is the responsibility of the HCCA to implement.
  - 2) The MeCare desktop application connects from the HCCA to the State via an IP address to IP address with TCP ports.
  - 3) Any changes to this configuration or changes to the HCCA'S internal firewall/architecture that could potentially affect the MeCare application must be communicated to BEAS and the Bureau of Information Services, Network Services Division (State of Maine) 3 to 5 working days prior to implementation to confirm that it will not affect MeCare's performance and/or connectivity.
- K. Assure that all HCCA staff work cooperatively with the social work and nursing staff in acute care hospitals and nursing facilities regarding discharge needs of current consumers.
- L. Provide consumers with the identification card that indicates the consumer is a current participant in a home care program. The HCCA must assure that staff explain the role of the HCCA, and provide written information to the consumer about how their home care services will work.

M. Implement a waiting list when expenditures are projected to exceed revenue.

N. Conduct specified utilization review activities to determine that:

- 1) Adjustments to authorized care plans were made according to BEAS Policy and that consumers received notification of the temporary adjustments.
- 2) Private insurance and federally supported programs and services are used before accessing State funded programs or services.
- 3) The least restrictive and/or most cost effective service is used.
- 4) Conduct random audits of 20% of provider agency records to determine that services provided and billed are consistent with service authorization, and that entrance and exit times have been documented for all individual providers.
- 5) Take corrective actions with provider agencies within 30 days of determining variances of more than 10% from services provided versus service orders.
- 6) Identify the number and types of discrepancies, the reasons for discrepancies in levels, types and amounts of services, between authorized and implemented care plans.

O. Working cooperatively with the:

- 1) Bureau of Family Independence regarding determination of financial eligibility and/or cost sharing (cost of care) for consumers for long term care programs included in the HCCA contract.
- 2) Assessing Services Agency that determines and establishes eligibility and authorizes the plan of care for consumer home care services.
- 3) Bureaus of Elder and Adult Services, Medical Services, and Family Independence developing contract performance standards, incentives and sanctions.
- 4) Provider agencies delivering services to consumers served under the HCCA contract.

P. Be present at hearings and provide qualified, knowledgeable staff to defend termination, reduction, or denial decisions in the event consumers appeal the decisions rendered by the HCCA. Prior to issuance of any termination, denial or reduction notices, have all correspondence reviewed by a supervisor for compliance with policy and due process, date and time parameters. Furthermore, assure that verbal and written notice dates are consistent and in compliance with policy requirements. This includes providing copies of all documentation relied on in making these decisions for examination at the administrative hearing.

Q. Bill to Home Based Care funds the cost of:

- 1) Services received by a consumer in the event that Medicaid Waiver reimbursement is denied because a timely reassessment has not been completed by the ASA.

This does not apply to a lapse in medical eligibility coverage due to hospitalization of the

consumer at the time the reassessment is due or an untimely reassessment request by the HCCA. The HCCA is responsible for alerting the ASA that the consumer is ready for discharge and that the reassessment can be completed prior to resumption of waiver services.

- 2) Delinquent Waiver cost of care payments incurred by consumers. In such cases, termination of waiver services will be initiated according to policy.

The Department reserves the right to make reasonable modifications to policies and procedures without changing the scope of work. However, the Department agrees to provide timely written notice to the HCCA of any changes in policy or procedures that govern performance under a contract. Wherever possible, the Department will provide thirty (30) days advance written notice, unless to do so would result in non-compliance with policy. If less than thirty (30) days notice is given involving changes in the MED form and MeCare, the Department will assist the HCCA in disseminating the information and assisting with applicable training. The Department will consider funding required changes in the scope of work or policy changes that result in additional cost to the HCCA. However, the HCCA must demonstrate what the financial impact of the change order is, and that additional costs have been incurred.

### ***PERFORMANCE AND SANCTIONS***

In the event the HCCA fails to perform any substantial obligation under the contract, or has otherwise committed a breach of the contract, the BEAS may withhold all or a portion of the HCCA fee, until such failure is resolved to the BEAS' satisfaction. Major obligations may include, but are not limited to, performance requirements such as:

- A. Contacting clients within the required timeframe to implement care plan
- B. Performing required monthly telephone contacts and quarterly face-to-face visits with consumers
- C. Implementing the care plans as authorized and within allowable parameters
- D. Assuring accuracy of invoices, and that other appropriate sources are billed before Home Based Care
- E. Reimbursing providers within required timeframes

All performance requirements and sanctions will be detailed in the contract with the HCCA.

### ***MECARE OVERVIEW***

MeCare is a three-tiered Oracle based application containing data on all client assessments. In addition to capturing client demographic data at intake, MeCare facilitates the clinical assessment, recording all clinical details gathered during the assessment by RN assessors using laptops, as well as capturing Medicaid eligibility information from the State. Data gathered on laptops is uploaded to the MeCare server via dial-up connectivity. On a nightly basis, MeCare sends an encrypted (using PGP) flat file to the Home Care Coordinating Agency (HCCA) on clients the HCCA is responsible for. In turn, the HCCA sends MeCare an encrypted nightly feed containing actual care plan data on its clients. (See Attachment 4.) Basic demographic information on clients is contained in 5 screens, including

referral information, general information, contacts, outcome, and care plan information. Additionally, six screens contain the clinical detail on each consumer's assessment.

Other MeCare characteristics and requirements include:

- A. The out feed from MeCare provides assessment detail data to the HCCA. This data is used to assist the HCCA with the creation of service orders for MeCare clients that have been determined to be eligible for certain program services.

The initial output feed file is named **MEmmddy.out** where **mm** is the month and **dd** is the day and **yy** is the year that the file was created. The encrypted output feed file is named **MEmmddy.pgp** where **mm** is the month and **dd** is the day and **yy** is the year that the file was created. This is the file that is sent via FTP to the HCCA. The encrypted file is currently sent to a hard coded IP address. Files sent back to MeCare use the same naming convention, but with a different prefix.

- B. The outgoing feed file is created daily at 01:00 AM, and then transferred to the HCCA using FTP. The HCCA must be able to process these feeds in a timely fashion.
- C. The business rules determining what data is sent may be changed periodically to reflect additional program funding sources, or other data changes in the assessment plan of care. The HCCA will be expected to make the necessary modifications to their internal system to accommodate these changes.
- D. The successful respondent will have to establish a connection to the MeCare server in order to use MeCare as well as process nightly feeds. This may be done by a variety of methods, including a dedication T1 connection, or via an existing Internet Service Provider (ISP). The method of connection is dictated by a variety of factors, including whether there is any existing corporate connection to the Internet, etc. For technical details regarding connecting to the MeCare server, contact Dennis Stevens with the State of Maine Bureau of Information Services/Network Services at 624-8800.
- E. The HCCA will also be expected to have in place a system capable of processing these incoming nightly feeds from MeCare and generating the actual care plan data back to MeCare. In addition, they will be expected to provide the Bureau access to whatever internal system they have for managing the services and clients, to allow the Bureau to monitor and determine current client services. In addition, the HCCA must be able to generate the requisite files electronically the Bureau of Medical Services for Medicaid reimbursement (for more information, contact Valorie Howard at BMS at 287-3704), and database files to BEAS for state funded reimbursement.
- F. The data format of the out feed file is a modified FML fielded buffer format. The fielded buffer format consists of three columns. The first column is the FML field name, the second column represents the occurrence number of that field, and the third column is the data value of the field. Each record within the file is bracketed by lines containing #RECORD:X and #END:X where X is a sequential number starting at 0 (zero). See Attachment 4 for a sample of the EIM out feed

file. (Note that the actual record is quite lengthy, as it contains every data element in the assessment.)

### **SECTION III**

### **PROPOSAL TIMELINE**

February 4, 5, & 6	Ad/legal notice appears in newspapers announcing the RFP, date of informational meeting/bidders' conference, and deadline for filing letter of intent to bid
February 14	Informational meeting/bidders' conference and MeCare demonstration
February 21	Deadline for submitting questions; all questions must be in writing
March 19	Deadline for filing letter of intent to bid
March 22	Qualified bidders notified
April 19	Deadline for submitting proposals

## **SECTION IV**

### **CONTENT OF PROPOSAL**

Any proposal that does not conform to the requirements of this section might not be considered. The proposals must be submitted on 8 ½" x 11" paper, using size 12 font, with a single fastener or staple in the upper left-hand corner. Any changes or corrections must be initialed by the person making them. **DO NOT submit bound copies, glossy covers, or advertising material.**

All proposals should include:

A. A completed cover letter, using Attachment 2.

B. Descriptions of:

- 1) The respondent's qualifications and capacity to provide HCCA services, including an explanation of how any necessary expansion of current capacity would occur to meet the service requirements.
- 2) The respondent's current technological capacity, what expansions might be necessary, and how the respondent will integrate with the MeCare system and the activities and tasks outlined in item H on page 12.
- 3) The activities and methods to be used to implement, administer, and provide all of the activities and services specified in Section II, Scope of Work.
- 4) Staff to be used, including front-line staff, supervisory, technical support, and administrative.
- 5) Training to be provided to staff, both initial and ongoing.
- 6) Respondent's proposed timeframes for responding to calls from consumers, families, providers, and the Bureau of Elder and Adult Services.
- 7) Quality assurance performance standards and measures.
- 8) How the respondent will approach problem identification, tracking and resolution. How corrective action will be taken in situations where performance and/or quality of work does not meet the RFP requirements.
- 9) The proposed plan for transitioning consumers and providers, timeframe, and related costs, if respondent is not the current HCCA.
- 10) The financial structure and controls of the agency, and how those controls will be effective in protecting expenditures under the contract.

C. Discuss what, in the respondent's opinion, are the most critical aspects of providing the HCCA function.

D. Job descriptions and resumes where available for key management staff.

E. Provide a detailed explanation of how the proposed HCCA unit cost was determined and of what the proposed average caseload per licensed FTE would be, based on average monthly caseload of 3,650 consumers. The Department will not accept any proposed unit cost (HCCA fee) of more than \$117 per unit per month.

F. The following completed forms from the Standard Contract: (A complete copy of the Standard Contract is in Attachment 3.)

- 1) Certification of Authorization; and
- 2) Budget (Rider E).

G. Following additional items:

- 1) An organizational chart for the entire agency, also indicating how this program fits into the larger organization.
- 2) A copy of the respondent's latest audited financial statement.
- 3) Evidence of bonding or description of bonding which will be obtained.
- 4) Evidence of the respondent's liability insurance.
- 5) A description of any relationships the respondent, or its subcontractors, may have or have had with the State over the last twenty-four (24) months. If no such relationship exists, the respondent must so declare.
  - a. If the respondent, or its predecessor, or any subcontractor in the respondent's proposal has contracted with the State, identify the contract number and/or any other information available to identify such contract(s). If no such contracts exist, so declare.
  - b. If any party named in the proposal is or was an employee of the State of Maine within the past twelve (12) months, identify the individual(s) by name, Social Security number, State agency by which employed, job title or position held with the State, and separation date. If no such relationship exists, so declare.
- 6) A description of any contract termination of the respondent, which occurred before completion of all obligations under the initial contract provisions, for default, non-performance, or any other reason, during the past three (3) years. If no such early terminations have occurred in the past three years, so declare.

**SECTION V**  
**PROPOSAL REQUIREMENTS, PROCEDURES**  
**AND REVIEW CRITERIA**

**A. IMPORTANT DATES AND CONTACTS**

(See also Section III, Proposal Timeline, on page 18 for other dates.)

- 1) Any questions regarding the RFP must be received by the Bureau of Elder and Adult Services **in writing no later than 4:00 p.m. on February 21, 2001**. All questions should be addressed to:

John Baillargeon  
Bureau of Elder and Adult Services  
35 Anthony Avenue  
11 State House Station  
Augusta, ME 04333-0011  
Fax: (207) 624-5361  
Email: [john.baillargeon@state.me.us](mailto:john.baillargeon@state.me.us)

- 2) The deadline for submitting a "Notice of Intent to Bid" is **March 19, 2001, no later than 4:00 p.m.**, and it must be submitted to:

AnnMarie Stevens  
Bureau of Elder and Adult Services  
35 Anthony Avenue  
11 State House Station  
Augusta, ME 04333-0011  
Tel: (207) 624-5335    Toll Free: 1-800-262-2232  
TTY: (207) 624-5442 or Toll Free: 1-800-720-1925  
Fax: (207) 624-5361

- 3) **Seven (7) copies** of proposals identified as "Response to BEAS Home Care Coordination RFP" **must be received by April 19, 2001, no later than 2:00 p.m.** at:

Department of Administration and Financial Services  
Division of Purchases  
Capitol Street  
9 State House Station  
Augusta, ME 04333-0009

**Proposals will NOT be accepted AT the Bureau of Elder and Adult Services.**

## B. PROPOSAL REQUIREMENTS AND PROCEDURES

- 1) Rights of State Government. The Department reserves the right to reject any and all proposals and to request additional clarifying information. Issuance of this Request for Proposals in no way constitutes a commitment by the State of Maine to award a contract. The entire cost for the preparation and submission of a proposal, and the attendance at any oral presentation, or personnel interviews will be borne by the respondent.

The Department reserves the right to make a contract award without any further discussion with the respondents regarding the proposals received. The Department, however, reserves the right to conduct discussions with any qualified respondents who submit proposals determined to be reasonably likely of being selected for award.

- 2) Disclosure of Information. According to State procurement law, the content of all proposals, correspondence, addenda, memoranda, working papers, or any other medium which discloses any aspect of the Request for Proposals process will be considered public information when the award decision is announced. This includes all proposals received in response to this RFP, both the selected proposal and the proposal(s) not selected, and includes information in those proposals that a respondent may consider to be proprietary in nature. Therefore, the State makes no representation that it can or will maintain the confidentiality of such information.
- 3) Communications with State Staff. From the date of issue of this RFP and until a determination is made and announced regarding the selection of a vendor, all contact except those made pursuant to any pre-existing obligation, with personnel employed or contracted to the State of Maine must be approved in writing by the BEAS Administrative Services Manager. The only exception to this restriction is State personnel involved in oral presentations or personnel interviews. Violation of this provision may result in disqualification of the respondent's proposal. Respondents are advised that only the BEAS Administrative Services Manager can clarify issues or render any opinion regarding the RFP. No individual member of the Department, employee of the State, or member of the selection committee is empowered to make binding statements regarding this RFP. The BEAS Administrative Services Manager will issue any clarifications regarding the RFP in writing.
- 4) Written Questions and Answers. Requests for clarification regarding the meaning of any RFP provision must be submitted in writing to the BEAS Administrative Services Manager. Questions may be transmitted by FAX but must include a cover sheet clearly indicating that the transmission is to the attention of the BEAS Administrative Services Manager. Questions may also be sent via email. The Department assumes no liability for assuring accurate/complete FAX or email transmission/receipt and will not acknowledge receipt except by addressing the questions received. **Under no circumstances will questions asked in other than written form be considered.**

The Department will respond in writing to all substantive questions received. Only those answers received in writing will be considered binding. Any information given to respondents concerning the RFP including written questions and answers will be furnished to all respondents who have received a copy of the RFP from the BEAS.

- 5) Amendments to RFP. The Department reserves the right to amend the RFP prior to the proposal due date. All respondents who received a copy of the RFP from BEAS will be notified in writing of any amendments to the RFP a minimum of seven (7) days prior to the due date. Should an amendment be issued with fewer than seven (7) days remaining prior to the date, the due date will be extended. The Department will not be responsible for any additional costs incurred as a result of any such changes in the RFP.
- 6) Oral Presentations. At the Department's option, oral presentations by respondents may be requested for the purpose of explaining or clarifying characteristics or significant elements related to the proposals. Respondents will not be allowed to alter or amend their proposals through the presentation process. Respondents will not be permitted to attend competitor oral presentations. The Department reserves the right to require and conduct oral presentations with respondents who submit proposals determined to be reasonably likely of being selected for award.
- 7) Personnel Interviews. At the Department's option, personnel proposed by respondents may be requested to participate in a structured interview to determine their understanding of the service requirements, their authority and reporting relationship within the firm, management style, and any other relevant information. Respondents will not be allowed to alter or amend their proposals through the interview process, nor will they be permitted to attend competitor interviews.
- 8) Proposal Evaluation. An evaluation team selected by the Bureau of Elder and Adult Services will rate proposals using review criteria included in the table on Review Criteria. Where items do not lend themselves to a strict numerical evaluation, a subjective rating based on the collective opinion and experience of the selection committee will be used. Prior experience with the Department may be considered. The Department reserves the right to contact individuals, entities or organizations who have had recent dealings with the firm or staff proposed whether they are identified as references or not.
- 9) Review and Acceptance of Proposed Costs. The Department reserves the right to review all aspects of the proposed budget for reasonableness and to request clarification.

The Department will not negotiate any contract that exceeds a HCCA unit cost of \$117. The Department further reserves the right to terminate contract negotiations with a selected respondent who submits a proposed contract significantly or materially different from the proposal submitted in response to the advertised RFP.

- 10) Acceptable Contract. If for any reason the Department is unable to obtain an acceptable contract with the selected respondent, the selected respondent will be disqualified. In this event, the Department may then proceed to negotiate a contract with the respondent with the next highest rated proposal, or may cancel negotiations entirely at the Department's discretion.
- 11) Written Notice. Notification of selection or non-selection will be by certified mail.
- 12) Contract Approval. The Bureau of Elder and Adult Services will make the decisions regarding the selection of a contractor and the contract award, subject to the approval of the Commissioner of the Department, the State Contract Review Committee, and the State

Comptroller.

Any contract awarded under this RFP will be subject to all rights of appeal as provided in the State Purchasing Office appeal procedures.

- 13) Standard Contract Agreement. Standard terms and conditions are contained in the State of Maine Standard Agreements, attached to this RFP. The final contract shall contain all terms and conditions, unless otherwise agreed to by the parties.
- 14) Conflict of Interest. All respondents must disclose any conflict of interest or pecuniary interest, including conflict as a result of an entity related by ownership or control. Conflict of interest occurs when staff are in a position to arrange any long-term care services provided by the respondent or an entity related by ownership or control. Long-term care services include care management, personal care, homemaker services, home health, speech, occupational or physical therapy, adult day or adult day health services, residential or nursing facility care, or any other service that might be arranged as part of a consumer's service plan. Proposals will be rated on the degree of conflict of interest, with those demonstrating less conflict receiving higher scores.

### C. REVIEW CRITERIA

	Possible Points
A Proposal includes all information and forms required in Section IV, Content of Proposal.	5
B How well respondent addresses all items in Section IV, Content of Proposal, item B (descriptions of 1-10).	15
C Respondent's description of qualifications and capacity to meet the scope of work are clear and credible.	5
D Proposed staffing, technical and administrative structure assure sufficient management support for the program. The proposal reflects an average caseload size of 70 consumers per licensed, full-time equivalent staff. If lower average caseload size, is the cost realistic?	15
E Respondent proposes computer and other infrastructure sufficient to implement the scope of work and conveys an understanding of MeCare	10
F Proposed staff training plan and content demonstrate an understanding of the HCCA function.	5
G Proposed quality assurance and consumer satisfaction plans reflect a commitment to quality service.	10
H Does the budget reflect all the costs for the work proposed?	10
I Unit Cost (UC): Lowest UC/UC of respondent X 25 =	25
<b>Total Score</b>	<b>100</b>

**ATTACHMENT 1**  
**Request for Proposal**  
**Home Care Coordination Agency - 2001**  
**QUALIFICATION TO BID FORM**

This form must be submitted with the letter of intent to bid. Agencies that cannot document sufficient organizational and fiscal capacity to manage a complex, statewide project, as described in Section II of this RFP, will be deemed ineligible to bid.

Applicant: \_\_\_\_\_

List the following if not provided on letterhead:

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Names of Principles: (use additional sheets if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary Contact: \_\_\_\_\_

Telephone #: (if different) \_\_\_\_\_

Email: \_\_\_\_\_

Please respond to the following:

- 1) Describe nature of the agency or corporation's business and length of time in business. (No more than one page.)
- 2) Does the agency or corporation have either agency cash flow/funds **or a line of credit** in the amount of \$1 million to undertake startup, plus funds needed to maintain operation of current business for two months?
- 3) Describe the human resource, technology and accounting/fiscal management capacity of the agency or corporation. (No more than two pages, single spaced.)

## **ATTACHMENT 2**

### **COVER LETTER**

Date: \_\_\_\_\_

Respondent Organization: \_\_\_\_\_ is committed to negotiate a twelve (12) month contract with a provision for four additional one-year periods as the Home Care Coordination Agency with the Department of Human Services pursuant to satisfactory performance. Second, third, and fourth year contracts may be amended in scope of work or cost, contingent upon funding sources.

Address of Organization's Principle Location:

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of the **Authorized Agent** empowered to enter into contracts on behalf of the organization submitting the proposal: \_\_\_\_\_

The name, title, address, telephone number, and position description for a **Primary Contact**. The Primary Contact person must be able to respond to or obtain answers to questions about the proposal in a timely manner and will have the authority to commit the vendor to statements made by the Primary Contact.

Primary Contact & Title: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

**The Authorized Agent of the Respondent assures and agrees to the following:**

"All of the rights of the State including the procurement rules and procedures, terms and conditions, and all other rights and terms specified in this RFP."

"A willingness to enter into an agreement with the State which includes the terms and conditions included in the sample Standard State Agreement & Budget in Attachment 4."

"All information provided in the enclosed proposal, both program and fiscal, is to the best of my knowledge correct and accurate at the time of submission."

"The proposal meets all the requirements set forth in the RFP. When implemented, the services will meet all the specifications set forth in the RFP."

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Authorized Agent)

**ATTACHMENT 3**  
**SAMPLE OUT FEED FILE FROM**  
**ELDER INDEPENDENCE OF MAINE (THE CURRENT HCCA)**

#RECORD:0

Age;1:94

APPPoverty;1:0

AssessmentId;1:2047468

CognitionPerfScore;1:2

ContactId;1:1

ContactId;2:2

ContactId;3:3

HHPoverty;1:181

IncomeFrequency;1:Monthly

IncomeFrequency;2:Monthly

IncomeRecipient;1:Applicant

IncomeRecipient;2:Applicant

IncomeSource;1:Social Security

IncomeSource;2:Pension

InsuranceName;1:Medicare Part B

InsuranceName;2:Blue Cross

NFNumDays;1:0

NumHousehold;1:1

OutcomeFundingSource;1:14-Home Based Care

.

.

Directions;1:This is a free form text field.

.

.

.

HomeBoundStatus;1:U

NFDetlMHHEndDate;1:

#END:0

#RECORD:1

.

.

.

#END:1

**HCCA Infeed Example**

#RECORD:0

:AssessmentId: 1178666

```
:ProviderId:EIM
:SrvOrderKey: 90512
:SrvCategory:CNA
:SrvUnitCodeDesc:Half Hour
:SrvStartDate:12/28/1999
:SrvEndDate:12/25/2000
:SrvFrequency:WEEK
:SrvPerMonthAmt:2683.08
:SrvNumberOfUnits:81
:ProgramDesc:Medicaid Waiver
:Reason:12,13,14,15,16,17,19,21,22
:MedicarePayInd:N
:HBCCopayReasmtDueDate:
#END:0
```

```
#RECORD:1
:AssessmentId: 1178666
:ProviderId:EIM
:SrvOrderKey: 88069
:SrvCategory:RN - Licensed Agency
:SrvUnitCodeDesc:Half Hour
:SrvStartDate:12/28/1999
:SrvEndDate:12/25/2000
:SrvFrequency:YEAR
:SrvPerMonthAmt:29.08
:SrvNumberOfUnits:24
:ProgramDesc:Medicaid Waiver
:Reason:01,02,03,06
:MedicarePayInd:N
:HBCCopayReasmtDueDate:
#END:1
```

MeCare Outfeed Example:

## **BEAS Billing File Structure:**

The HCCA currently sends two files to the Bureau for reimbursement for state funded programs. The file structure for these two files are listed below. The first provides a record for every beginning date and end date of eligibility for each client. The second provides information on services provided to each client, including the service begin and end dates, cost, units provided, service code and funding source.

BSADnnnn:

1	CLIENTID	Character	8	Asc	Machine
2	PROGRAM	Character	4		
3	TYPE	Character	4		

4	BEGDATE	Date	8
5	ENDDATE	Date	8

BEASnnnn.DBF:

1	LAST	Character	20	
2	FIRST	Character	25	
3	BEGDATE	Date	8	
4	ENDDATE	Date	8	
5	COST	Numeric	8	2
6	UNITS	Numeric	3	
7	BILLCODE	Character	5	
8	CLIENTID	Character	8	
9	PROGRAM	Character	4	
10	SERVCODE	Character	2	
11	SSN	Character	11	
12	FUNDSRC	Character	2	
13	UOM	Character	10	
14	PIKEY	Character	8	
15	LINENUM	Character	2	
** Total **			125	

## **ATTACHMENT 4**

### **STANDARD STATE AGREEMENT AND BUDGET**